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PRIMARY HEALTH CARE AND THE PEOPLES' PERSPECTIVE IN DEFINING HEALTH AND ILLNESS

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ABSTRACT
In most traditional communities definitions of health and illness intertwine with local beliefs and customs, and part of social and cultural facts that constitute everyday reality for the people. The basic principles of primary health care advocate essential health care that is scientific, and practical provided within a social and cultural context, using appropriate technologies readily available, with active participation of the people. This requires redefinition of roles and reoreintation of health care professionals working in rural community. Despite adoption of PHC and numerous efforts to deliver services to rural , Nigerian health indicators are poor and worse in ruarl communities. National Population Commission (2009) reports huge disparities in pregnancy outcomes between urban and rural communities,f still births for urban was 72 and rural 156; early neonatal deaths 221 for urban and 649 for rural. Nearly fifty per cent 46.9 % of women in rural communities did not receive care from anyone, 73.1% had their babies at home, 69.9% did not have post natal check up. Primary health services are juxtaposed alongside local cultures, beliefs, and numerous traditional health practices and practitioners, and experiences of health and illness inextricably tied to the vast complexities of family, and social network. This paper advocates understanding and integrating the perspectives of rural communities in defining health and illness, assessing health needs, planning and implementing primary health care interventions.

KEYWORDS: Primary Health Care, Defining Health and Illness, Perspective of Rural Communities in Primary Health Care.

INTRODUCTION

Many who choose health care as their profession, considering the physical, mental and emotional demands are presumably altruistic, with a desire to relief others pain and suffering. Fundamental to effective alleviation of pain and suffering is empathy, the hallmark of health care professions, that stems from understanding human being, and their hopes, beliefs, and fears about ill health. From the period of the Greek Asclepius and Hippocrates discussions on the issue of health and illness have tended to be intense and complex. Earlier, health was seen as the state of balance, homeostasis or equilibrium and illness a condition of misbalance that requires correcting. What constitutes the state of equilibrium varies, Hippocrates for instance advocates understanding mind and body, the treatment of the 'whole person'.

Today, health care professionals with western oriented training tend to have such abstract view of health and illness devoid of local realities and often inconsistent with local definitions. Such perspective stem from western orthodox training, understandably guide practice, and interpretation of client's condition. This may not pose problem when health professionals deal with clients in urban general or teaching hospitals, rather problematic in traditional rural communities where local values, norms, health beliefs and practices are dominant. In most traditional communities definitions of health and illness intertwine with local beliefs and customs, part of social and cultural facts that constitute everyday reality for the people. Understanding illness behaviour invariably requires understanding the ill person's perspective, and the context and culture that mould interpretation and behaviour.

Hence, definition of health and illness at the primary health care level in rural communities transcend the purview of health care providers, and rather complex. The question is should health care providers strive to understand local peoples' perception and interpretation of health, illness and disease conditions or should the dominant orthodox interpretation always prevail? Cultural differences between science and tradition are more obvious in public health and preventive medicine because practitioners work with groups and have greater difficulty adjusting health care approaches than a clinician dealing with individuals (Bannerman, Burton, and Wen-Chieh 1988).

This paper advocates understanding and integrating the perspectives of rural communities in defining health and illness, assessing health needs, planning and implementing primary health care interventions.

Primary Health Care

Primary health care (PHC) became the backbone of many health systems after the 1978 Alma Ata Declaration. Nigeria restructured the health system creating three levels of integrated and interconnected health system with primary health care as the entry point. Basic principles of primary health care advocate essential health care that is scientific, and practical provided within a social and cultural context, using appropriate technologies readily available, with active participation of the people. This requires redefinition of roles and reoreintation of health care providers, particularly in rural communities where majority of people live. Chan (2008) redirected the world's attention back to primary health care advocating reforms that contribute to health equity, social justice and the end of exclusion, primarily by moving towards universal access and social health protection. Health reforms serve to make health services more socially relevant and more responsive to the changing world while producing better outcomes. Equally, development requires building up and nurturing processes for meaningful involvement of people in defining possibilities for action, and making responsible choices at personal and collective levels (Adindu and Romm, 2001). Furthermore, conceptualising health and illness vary according to culture, beliefs, social class, sex, age, and the structure of people's everyday life. People hold a multiplicity of accounts of health and illness due to the multifaceted nature of people's lives and lifestyles (Nettleton, 1996). Satisfying health care clients has become critical issue in the delivery of health services, particularly at the primary health care level in rural communities. The culture and social reality of the people are important elements for consideration in the health planning process and in effective delivery of quality services that meet health needs of people in a context.

Moreover, in Nigeria and other African countries alternative and traditional systems of health care are ubiquitous and strong, particularly in rural communities where estimated 80% of the populations live. Despite adoption of PHC and numerous efforts to deliver services to people in rural communities health status indicators have remained poor, and Nigeria ranks among the countries with highest child and maternal mortality rates. World Health Organisation (2010), report shows that major health indices in the country have remained below expectation for decades when compared with those of even poorer African countries (Table 1).

Similarly, National Population Commission (2009) reports huge disparities in pregnancy outcomes between urban and rural communities in Nigeria during the survey periods for instance number of still births urban was 72 and rural 156; early neonatal deaths 221 for urban and 649 for rural (table 2). The survey further shows that a large proportion of rural women have unassited births at home, 46.9 % of women in rural communities did not receive care from anyone, 73.1% had their babies at home, 69.9% did not have post natal check up (table 3). This is rather disturbing, and an indication that the gap is still wide, critical elements are missing that must be addressed for orthodox health care services to achieve desired objectives in rural communities.

Culture and Primary Health Care

Culture and other variables within a context affect the definition of health and illness. People acquire mental programmes that lead to the creation of patterns of thinking, feeling and action, and culture is the collective programming of the mind, which distinguishes members of one group from another (Hofstede, 1990). The study of culture implies understanding social significance of how things, events and interactions become meaningful, leading to the study of the world (Berger and Luckmann, 1967; Geertz,1983). Cultural contents vary among societies and within societies, these influence people's perceptions, interpretations, and their responses to health and illness. Understanding the cultural context of health and illness particularly in traditional rural communities enhances understanding of health behaviour, and helps to predict progression of illness, utiliasation of services, and compliance to treatment. Furthermore,in many rural communities ascribed roles for women, perception about what a woman is and ought be, and attitudes toward women are still rigid, ingrained in social milieu, difficult to change, and influence health seeking behaviour. Culture, norms and values of traditional communities are strong binding forces that hold the people together. Abdullahi (2009), indeed argues that culture is dynamic and serves the needs of individuals, and groups biological, social, coordinative and integrative basic needs; and provides individuals in the community with psychological security, social harmony, and purpose in life.

Table 1: Life Expectancy and Infant Mortality Rates for Ten African Countries

	Life Expectancy at Birth				Infant Mortality per 1000 Live Births		
Country	1990	2000	2008		1990	2000	2008
Angola	42	44	46		154	141	130
Benin	51	55	57		111	89	76
Cameroon	55	52	53		92	91	82
Ghana	58	58	62		75	71	51
Kenya	60	51	54		68	81	81
Malawi	47	47	53		133	100	65
Nigeria	46	47	49		120	107	96
South Africa	63	58	53		44	52	48
Uganda	47	45	52		114	98	84
Zambia	52	43	48		105	104	92

Source: WHO (2010). World Health Statistics Report, WHO Geneva

Table 2: Urban and Rural Outcome of Pregnancy in Nigeria 5 years Preceding Study

Outcomes	Urban	Rural
Number of pregnancies 7+ months duration	8,431	19,898
Number of stillbirths	72	156
Number of early neonatal deaths 0-6 days of live births	221	649
Perinatal mortality rates per 1000 births	35	40
Childhood Mortality Rates for ten years preceding survey	Urban	Rural
Neonatal Mortality (NN) rate per 1000 live births	38	49
Post – neonatal mortality (PNN) rate per 1000 live births	29	46
Infant Mortality rate per 1000 live births	67	95
Child Mortality rate per 1000 children 12 to 59 months	58	106
Under-five Mortality rate per 1000 live births	121	191

Source: National Population Commission (2009) Nigeria Demographic and Health Survey 2008. Abuja

Table 3: Urban and Rural Care During Pregnancy in Nigeria

Women age 15 - 49 who had live births five years preceding study	Urban	Rural
Number of Women in the survey	5,330	12,305
Received care from doctor	41.8%	14.7%
Received care from any health worker	45.4%	37.7%
No care from anyone	11.8%	46.9%
Other and missing	1.0%	0.6%
Total	100%	100%
Births five years preceding study by place of delivery	Urban	Rural
Number of births in the survey	8,359	19,741
Health Facility (public & private)	59.4%	24.7%
Home	35.9%	73.1%
Others and missing	4.6%	2.2%
Total	100%	100%
First post natal check-up for the last birth.	Urban	Rural
Number of women in the survey	5,330	12,305
Less than 4 hours	43.9%	21.7%
4 to 23 hours	7.4%	3.6%
2 days	7.2%	4.4%
3 to 41 days	4.2%	2.8%
No postnatal check-up	34.2%	65.9%
Don't know and missing	3.2%	1.7%
Total	100%	100%

Source: National Population Commission (2009) Nigeria Demographic and Health Survey 2008. Abuja

Achieving the objectives of primary health care requires understanding what constitutes health and illness in the various communities. The Alma – Ata Declaration pushes for integration of health care with the community social system. This stems partly from inability, unwillingness or failure of established medicine to meet the health needs of the people (Paine, and Tjam, 1988). Primary health care is not limited to community health services but may involve a broad range of programmes adapted to the patterns of disease and health of a collectivity, exact definition of services depends on the context.

Perspectives on Health and Illness

Medical Definition of Health

Professionals, scientists, communities and individuals have different definitions of health and illness. The familiar medical definition of health, a residual category, is simply the absence of disease or infirmity. An individualistic perspective derived from the biological sciences that guides medical education, emphasising curing of disease. The disease paradigm claims illness results from pathological processes in the biochemical functions of the body, while the engineering component sees the body as a machine subject to repair by technical means (Illsley, 1977). Focus is hence on specific causes of disease and individual cure, and contribution to definition of health is minimal. Health is an individual affair between the person and health institution or practitioner. This may well mean that a large number of population is healthy since only a small fraction visits health institutions; many visit traditional healers ubiquitous in rural communities.

Adaptation Perspective

This perspective advances the notion that other life related factors such as adaptation and coping mechanisms contribute to health and illness. Health, viewed in relation to response and behaviour toward stress and noxious stimuli is the ability to effectively cope and adapt in a dynamic environment; maintain integrity of structure, while changing nature and behaviour to respond effectively to situational demands. Health and disease are phases that result as people struggle to cope with multiple stressors posed by the environment. Hence, Engle (1975), perceives health to exist when an organism functions effectively as a whole, fulfilling needs, successfully responding to requirements of the environment, and pursuing biological destiny.

Functionalist Perspective

The human life transcends the pursuit of biological needs to include the accomplishment of activities of daily living, responsibilities, family expectations, and societal functions. Health is therefore a state of variability based on the ability to perform required functions, and optimum health measured by meeting normative reference point of desired capacity. Naegel (1970) sees health as condition necessary for the realisation of two dominant values: the mastery of the world, and fun. Health allows people to be what they want to be, and do what they want with a great deal of autonomy. On the other hand, Parsons (1958) argues health is a socially desirable and normative state, functionally important to the social system, and required for the maintenance of social system as a whole. Health is therefore the capacity to carry out roles and responsibilities effectively; a social rather than individual affair. Health transcends effective functioning of the biological domain; family, community and social groupings influence the definition of health and illness.

Balog (1981) however, argues that although evaluation of health status must somewhat be subjective and relative it is possible to establish essential criteria for the concept. Others argue that universally valid concept of health is unattainable because health is a value laden term with meaning tied to different objectives which govern its use (Boruchovitch, and Mednick, 2002). Many scientists agree that health refers to a number of entities and therefore a multidimentional concept (Dolfman, 1974; Laffrey, 1986).

CONCLUSION

Orthodox primary health services are juxtaposed alongside local cultures, beliefs, and traditional health practices and practitioners. Participation of individuals and the community in assessing health needs should include what constitutes health and illness within the social and cultural context. Health and illness transcend medical definition to include societal and individual variations and perceptions, continued adherence to narrow medical orthodoxies, particularly in rural traditional communities limits understanding of the patient health care needs, responsiveness to care and utilisation of services. Equally, involvement of patients in their care enhances the quality and effectiveness of care. Patients who are treated with dignity and are well informed and able to participate in treatment decisions are more likely to comply with their treatment plans (Mseleku, (2007). Furthermore, Yach (2008), argues that the health sector is a system through which society organises and manages the affairs of the sector in order to achieve the goals of health for all, and only with the collaboration of

the many actors can this be realised, since the roots of good health and causes of ill health lie outside the health services.

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